IDAHO RYAN WHITE MEDICAL CASE MANAGEMENT
INTAKE AND ELIGIBILITY DETERMINATION

Date of Intake/Eligibility Initiated
_____/____/_____

Client URN: _____

ADAP ID: _____

PERSONAL/CONTACT INFORMATION

Legal Last Name:	**Legal First Name:**	**MI:**
Preferred Name:		
Date of Birth: _____/_____/_____	**Gender**: □ Male □ Female □ Transgender □ Refused to Report □ Unknown	
Address:	**City:**	
County:	**State:**	**Zip Code:**
Mailing address if different from above:		
Phone (H) (____) _____-_____ **(W)** (____) _____-_____ **Cell/Pager** (____) _____-_____		
Emergency Contact/ Legal Guardian: _____ **Phone** (____) _____-_____ **Aware of HIV+ Status:** □ **Y** □ **N**		
Client Preference for Contact: □ phone □ phone message □ office visit □ home visit □ mail □ email (_____) Can talk to: 1) _____ 2) _____		
Are there any concerns related to the above contacts? If yes, please explain.		
Ethnicity: □ Non-Hispanic □ Hispanic □Unknown/unreported	**Preferred Language:**	
Race (may mark more than one): □ White □ Asian □ Black or African American □ American Indian or Alaska Native □ Native Hawaiian or Other Pacific Islander □ Other □ Unknown		

HIV STATUS

Proof of HIV Diagnosis? ☐ Yes ☐ No

Date of Original HIV Diagnosis (☐ Self-Report ☐ Medical Records) **_____/____/_____** (☐ Estimated)

State where diagnosed: _____ Original CD4 count: _____

AIDS Diagnosis? ☐ Yes ☐ No

Date of Original HIV Diagnosis (☐ Self-Report ☐ Medical Records) **_____/____/_____** (☐ Estimated)

Year first accessed care: _____ Original CD4 count at AIDS diagnosis: _____

HIV Status:

☐ HIV Positive (not AIDS) ☐ HIV Negative (affected)

☐ HIV Positive (AIDS status unknown) ☐ HIV Indeterminate

☐ CDC-Defined AIDS ☐ Unknown

Risk Factor (check all that apply):

☐ MSM ☐ IDU ☐ Hemophilia/Coagulation Disorder ☐ Heterosexual Contact

☐ Receipt of transfusion blood, blood components or tissue ☐ Mother with/at Risk for HIV

☐ Other (specify): _____ ☐ Unknown

Initial Idaho Ryan White Lab:

Current CD4: _____ Date of test: _____/____/_____

Current Viral Load: _____ Date of test: _____/____/_____

HIV Care Provider:

Name: _____ Phone: (____) _____-_____

Clinic Name: _____

Address: _____

INSURANCE INFORMATION

Do you have private health insurance? ☐ Yes ☐ No

If **yes**, is your health insurance through your current or previous employer? ☐ Yes ☐ No

If through previous employer, date COBRA Coverage began: _____/_____/_____

If **yes**, does your health insurance cover medications? ☐ Yes ☐ No

If **yes**, is there a total expense limit for medications? ☐ Yes ☐ No

Name of insurance company: _____

Address: _____

Phone: (____) _____-_____

Group #:_____ Policy #:_____

If no private insurance, what is your insurance status? (proof of insurance required for all)

☐ Medicare Part A/AB ☐ Medicare Part D ☐ Currently on Medicaid ☐ VA/ CHAMPUS

☐ Applied for Medicaid ☐ Uninsured ☐ Other (specify) _____

Date: _____/____/_____

HOUSING STATUS

Most Recent/Current Housing Status:

☐ Permanently Housed ☐ Non-permanently Housed ☐ Institutionalized

☐ Other (specify) _____ ☐ Unknown

FINANCIAL STATUS & ELIGIBILTY*

Sliding scale only applies to those with no other insurance coverage for services.

Household Size	**Individual Gross Monthly Income: $ _____ Household Gross Monthly Income: $ _____**		**Gross Individual Annual Income: $ _____ Household Gross Annual Income: $ _____**	
1	0– 902	903–1805	1806–2707	2708 & OVER
2	0–1214	1215–2428	2429–3642	3643 & OVER
3	0–1526	1527–3051	3052–4577	4578 & OVER
4	0–1837	1838–3675	3676–5512	5513 & OVER
5	0–2149	2150-4298	4299–6447	6448 & OVER
6	0–2460	2461–4921	4922–7382	7383 & OVER
7	0–2772	2773–5545	5546–8317	8318 & OVER
8	0–3084	3085– 6168	6169–9252	9253 & OVER
Level	**0 – 100%**	**101% - 200%**	**201% - 300%**	**Over 300%**
Eligibility	**Part B and C Eligible**	**Part B and C Eligible**	**Part C Eligible**	
Co-Pay	**$0**	**$10**	**$20**	**$ Pay in Full**
Co-Pay Maximum	**0%**	**5% of Individual Gross Annual $$**	**7% of Gross Individual Annual $$**	**10% of Gross Individual Annual $$**

*** Acceptable proof of income: Pay stubs or bank statements (last 2 months), last year's W2, last year's taxes, SSA Benefit Statement, SSA PEBE Report or Statement of No Income.**

CLIENT QUALIFIES FOR:
RWPB Medical Case Management _____ ADAP _____ RWPC Medical Case Management _____

Please indicate information has been gathered and shared by having client initial the appropriate box.	
Informational Forms (client provided copies and time for questions & answers):	***Client's Initials***
Client Rights and Responsibilities	
Complaint Grievance Procedures	
What You Need to Know About Idaho Laws on HIV	
Acknowledgement of Notice of Privacy Practices	
Other:	

Client Acknowledgement:
As a partner in this process, I acknowledge that:

1) All statements made by me are true to the best of my knowledge (_____).
2) The purpose of my participation in medical case management is to assure my engagement in HIV medical care (_____).
3) I will notify my medical case manager of any change in my health insurance status, financial situation, income, or living arrangements (_____).
4) This program involves the receipt of federal and/or state funds; any person supplying false information is subject to state and/or federal criminal prosecution, which may result in fines, imprisonment, or both. Additionally, there will be an automatic six month suspension from RWPB Programs and ADAP (_____).

_____ _____
Client Signature Date

_____ _____
Case Manager Date